WICHITA FALLS PARKS & RECREATION DEPARTMENT
DAY CAMP REGISTRATION FORM

*(Please **print** all information carefully and legibly)*

(1) Name of Camp: (Check only one below)

_____Creative Minds (Jefferson Elem.) (Ages 6 – 9) _____ Summer Fun (Scotland Park Gym) (Ages 6 – 12) _____ Lotsafun (Lucy Park) (Ages 6 – 12)

(2) Name of Camper: _____ Age: _____ Sex: _____

(3) Name of Parent/Guardian: _____

(4) Address: _____ City & Zip _____

(5) Phone #: (Home) _____ (Work) _____ (Cell) _____

(6) Emergency Contacts: (May be both parents but there must be at least 1 person we can reach at all times child is in camp)

Name	Relationship (to child)	Daytime Phone #
_____	_____	_____
_____	_____	_____

(7) Please check the session(s) desired below:

☐ Session #1 June 6th – June 17th ☐ Session #3 July 5th – 15th

☐ Session #2 June 20nd – July 1ST ☐ Session #4 July 18th - 29th

(8) Important!!! Please **initial** that you have read the items below, next to each.

a. _____ **No refunds** due to limited camp space.

b. _____ To reserve more than one session, the initial session for the above child must be paid in full and a **non-refundable $10.00 deposit** paid for each additional session reserved. The remainder must be paid at least **7 days (Friday) prior** to the beginning of each session held in reserve. If the balance is not received, your child's spot will be opened to others. If no others fill the spot, you may pay an additional $10 processing fee no later than 4:00 p.m. Friday prior to the start of the next camp session beginning Monday. **NO EXCEPTIONS!**

c. _____ I have read, understand and agree to abide by 'late pick-up' terms as stated in Authorization and Agreement portion of this packet.

LIABILITY WAIVER

I, the undersigned, realize there are risks involved in participating in this program; and hereby agree to indemnify, save, and hold harmless the City of Wichita Falls, the Parks & Recreation Department, Scotland Park Elementary School, Wichita Falls, ISD and all their agents & employees, for any injury or damages, which may result from my child's participation in this program. I further verify all the above information is correct.

(9) _____ _____

Signature of Parent/Guardian (Must be same name as parent/guardian above) Date

OFFICE USE ONLY

Session	Amount Due	Deposit	Date Paid	Receipt #	Balance	Date Paid	Receipt #
I		---				---	---
II							
III							
IV							

CITY OF WICHITA FALLS
PARKS & RECREATION DEPARTMENT
CAMPER PICK-UP AUTHORIZATION

Child's Name: _____

(Parents / guardians; please include yourselves below & print all information legibly)

Authorized Person #1 _____
Address _____
Phone (H) _____ (W) _____ (Cell) _____
Relationship _____

Authorized Person #2 _____
Address _____
Phone (H) _____ (W) _____ (Cell) _____
Relationship _____

Authorized Person #3_____
Address _____
Phone (H) _____ (W) _____ (Cell) _____
Relationship _____

Authorized Person #4 _____
Address _____
Phone (H) _____ (W) _____ (Cell) _____
Relationship _____

Authorized Person #5 _____
Address _____
Phone (H) _____ (W) _____ (Cell) _____
Relationship _____

Name of person(s) ***NOT*** allowed to pick-up above child. Please explain:

_____
_____
_____
_____

Appropriate custody paperwork MUST be attached if a relative is NOT allowed to pick-up the child.

_____ _____
Parent / Legal Guardian Signature Date

CITY OF WICHITA FALLS PARKS & RECREATION
DAY CAMP MEDICAL, AUTHORIZATION & AGREEMENT FORM

EMERGENCY MEDICAL AUTHORIZATION

I, _____ as parent and/or legal guardian, release the City of Wichita Falls, its staff & volunteers, from liability in the case of an accident or injury to my child:

Name: _____ Age: _____

Further, in case of accident, injury, or sudden illness, I authorize any first aid or emergency medical care that may become necessary for my child while he/she is enrolled in any City of Wichita Falls Day Camp. I also authorize that my child may be transported to a local medical facility. If I cannot be reached in an emergency, I hereby give permission to the physician on duty to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, named above. I understand I am financially responsible for any expenses incurred for medical care or transportation on my child's behalf. By executing this document, I hereby assume, on behalf of my child, all risk of injury or loss to which he/she may be exposed.

_____ _____

Parent/Guardian Signature Date

MEDICAL INFORMATION

In the event of an EMERGENCY, individuals will be taken directly to the nearest hospital. If time permits, what is your hospital preference? _____

If applicable, Name & Address of Family Physician: _____

_____

Please list any medical related allergies or conditions of your child:

PHYSICAL CONDITIONS	ALLERGIES	DISEASES	BEHAVIORAL
_____	_____	_____	_____
_____	_____	_____	_____

Please explain any special needs or problems your child may have: _____

_____

Camp staff is not permitted to administer medication to campers. Parents are encouraged to come to camp & administer medications. Please list any medications that you authorize your child to bring to camp for self-administration. All medications must be in original container (including over-the-counter) & staff notified. _____

_____

AUTHORIZATION & AGREEMENT (Please initial all and sign below)

_____ I understand that responsibility for my child will be assumed by the Parks & Rec. Day Camp only when he/she has checked in with an authorized staff member of the program.

_____ I understand that, due to program scheduling, my child should arrive at camp no later than 9:00 a.m.

_____ I agree to pay $2 for every 5 minutes late my child is picked-up after camp ends.

_____ I authorize the Parks & Recreation to transport my child by chartered bus, to & from activities & field trips.

_____ I authorize my child to go on staff-supervised walking field trips away from the camp.

_____ I authorize my child to engage in all program activities except as noted by me and/or recommended by our physician.

_____ I authorize the Day Camp to involve my child in appropriate water activities. His/her swimming ability is: **(circle 1)** ***poor moderate good***

_____ I have read and understand the rules and policies of the Day Camp(s) I am applying for, and agree to follow them as described in the information given to me.

My signature below constitutes my authorization & understanding for items initialed above.

_____ _____

Parent/Guardian (signature) Date

WICHITA FALLS PARKS & RECREATION DEPARTMENT
DAY CAMP MEDICATION FORMS

Before your child may take any medication at camp, you must provide a copy of the appropriate form, below, to the Head Camp Counselor of the camp in which your child is currently registered. If your child changes camps or does not attend consecutive sessions of the same camp, a completed form must accompany him/her to the next camp or upon return from a session break. Please print all information legibly on the forms & sign & date.

PARENT ADMINISTERED MEDICATION

Child's Name: _____ Camp Name: _____

Parent's Name: _____ Day/Emergency Phone # _____

Dates during camp you will administer medication: _____
Time you will administer medication: _____
Name of prescribed medication: _____
Physician's name & phone #: _____
Name of over-the-counter medication & pharmacy: _____
Reason for medication: _____
Dosage prescribed: _____
Potential side effects/ warnings associated with medication: _____

I agree to administer the above medication to my child at the campsite on the dates & times listed. I will notify the Head Camp Counselor each time I arrive to administer the medicine.

_____ _____
Parent's Signature Date

SELF-ADMINISTERED MEDICATION

Child's Name: _____ Camp Name: _____

Parent's Name: _____ Day/Emergency Phone # _____

Dates during camp child will take medication: _____
Time he/she will take medication: _____
Name of medication: _____
Physician's name & phone #: _____
Pharmacy (if over the counter): _____
Reason for medication: _____
Dosage prescribed: _____
Potential side effects/warnings associated with medication: _____

I authorize my child to self-administer the above medication on the dates & times listed. I assure that he/she will bring medication in the original container and only the necessary dosage for 1 day as prescribed by his physician or the over-the-counter container. I understand that the camp staff is NOT responsible for reminding my child of, or administering his/her medication, however he/she will notify staff when he/she is going to take medication and a staff member will monitor administration of the medicine.

_____ _____
Parent's Signature Date